CASE 1998-4

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Clinical History:

A 26 year old man with a one year history of progressively worsening polyuria and a three week history of memory loss presented with increasing somnolence and dizziness upon standing. Further information included a decreased libido and impotence within the past eight weeks. He had recently been evaluated by an endocrinologist and was found to have hypernatremia and hypogonadism [testosterone, 15.5 ng/dL (200-1200 ng/dL)]. The patient denied any visual symptoms, nipple discharge, or headaches. His past medical history was unremarkable. His physical exam was remarkable for orthostatic dizziness, unequal pupils, and partial loss of short and long term memory, with confabulatory amnesia. He was oriented to self, but not to place or situation. Extraocular movements were intact in all directions. No visual field deficits were noted. Cranial nerve examination was normal. No motor or sensory deficits were noted. Cerebellar function was normal, and deep tendon reflexes were normal and symmetrical. Abnormal serum values were: sodium 161 meq/L, chloride 121 meq/L, osmolality 315 mOsm/kg, phosphorus 4.9 mg/dL, ALT 47 U/L, AST 57 U/L, and prolactin 52.1 ng/mL (2.2-18.5 ng/mL). Abnormal CSF values were: glucose 165 mg/dL, and protein 87 mg/dL. An MRI showed a brightly enhancing hypothalamic lesion with extension into the third ventricle, and distortion of the region of mammillary bodies. The patient then underwent a bifrontal craniotomy for biopsy-resection of the hypothalamic lesion.

Material submitted: One H & E stained slide and one kodachrome of an electron micrograph from the surgical specimen.

Points for discussion: 1. Diagnosis
2. Prognosis